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BEAUTY WITHIN
MEDICAL AESTHETICS • SYNERGY CENTRE

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www.beautywithin.ca

Welcome to the office of Dr. Maria Tetelbaum at **Beauty Within (Medical Aesthetics)**
(Located within Synergy Centre Dental & Healthcare)
In order to provide you with the most appropriate and safe treatment, we need you to complete the following questionnaire. All information is strictly confidential and for our records only.

PERSONAL HISTORY **Date:** ________________________________

First Name (& preferred): ________________________________ **Last Name:** ____________________________

Date of Birth: D _______ M _______ YR ___________ **Age**: ________ **Pronouns:** She/Her He/Him Other: ______

Address: ____ City/Town:__________________ Postal Code: ____________

Telephone: (______) ____ May we leave a voicemail? YES / NO

Email: ____ Occupation: ____________________________

OHIP (health card) #: ____ Version Code: _________________
*(*Will only be used if dermatological/medical assessment and/or treatment is provided.)*

How did you hear about us? ____

MEDICAL HISTORY

Do you currently have:	**NO**	**YES**	**Details:**
Any **medical conditions?** History of major illness?			
Medications? (prescription, OTC, vitamins, herbal remedies, blood thinners)			List all:
Recent immunizations? (past month or less)			Date:
Allergies? (medications, bee/wasp stings, etc)			Describe reaction:
Have you recently had an infection of any kind?			When: Type of infection:
History of autoimmune disease? (i.e. lupus, psoriasis, rheumatoid arthritis, Crohn's, thyroid dysfunction, etc)			
History of neurological conditions? (i.e. multiple sclerosis, ALS, myasthenia gravis, Lambert-Eaton syndrome, Bell's palsy, etc)			
History of osteoporosis?			
Recent or upcoming dental procedures? (dental implants, cleanings)			Date:
Are you missing any teeth?			
History of gum disease?			

	NO	YES	Details:
Significant weight loss?			
History of eating disorder?			
Currently pregnant or planning pregnancy within the next year?			
Early menopause? (earlier than age 45)			
Do you smoke cigarettes?			How many per day:
Chronic sinus congestion or sinus issues?			

SURGICAL HISTORY

Have you ever had:	NO	YES	Details:
Cosmetic facial surgery?			Date:
Reconstructive facial surgery?			Date:
Facial trauma?			Date:
Orthodontic surgery?			Date:
Any upcoming surgeries/procedures of any kind? (eg. joint replacement, colonoscopy, etc)			Date:

SKIN HEALTH HISTORY

Do you have:	NO	YES	Details:
History of keloid scarring?			
History of hyperpigmentation or melasma?			
History of rosacea?			
History of acne?			
History of cold sores?			Date of last outbreak:
History of skin cancer?			
Do you regularly sun bathe or use tanning beds?			
Do you use sunscreen/SPF?			
Do you use any retinol based products?			
Do you have a skincare routine? (describe your routine)			

AESTHETIC TREATMENT HISTORY

Have you had treatment with:	NO	YES	Details:
Botulinum toxin (Botox, Dysport, Xeomin, Jeuveau, Nuceiva)			Date of last treatment:

	NO	YES	Details:
Temporary dermal fillers? (hyaluronic acid based; such as Juvederm, Restylane, Revanesse, Belotero, Teosyal, etc)			Date of last treatment: Areas treated previously:
Permanent dermal fillers?			Date of last treatment:
Biostimulatory dermal fillers? (such as Radiesse, Sculptra)			Date of last treatment:
Previous reaction to dermal fillers? Concerns/complications?			Please describe:
Micro-Needling / PRP treatments?			Date of last treatment:
Threads?			Date of last treatment:
Lasers?			Date of last treatment:
Chemical peels?			Date of last treatment:
Other cosmetic treatments: ______________________			Date of last treatment:

REQUIRED: **I acknowledge that I have read, understood and answered the above questions related to my health and medical history to the best of my knowledge.**

Patient Name: ____ Date: ___________________________

Patient Signature: ____

MAIN REASON FOR SEEKING AESTHETIC TREATMENT (please share below)

____

____

OTHER AESTHETIC CONCERNS (please share below)

____

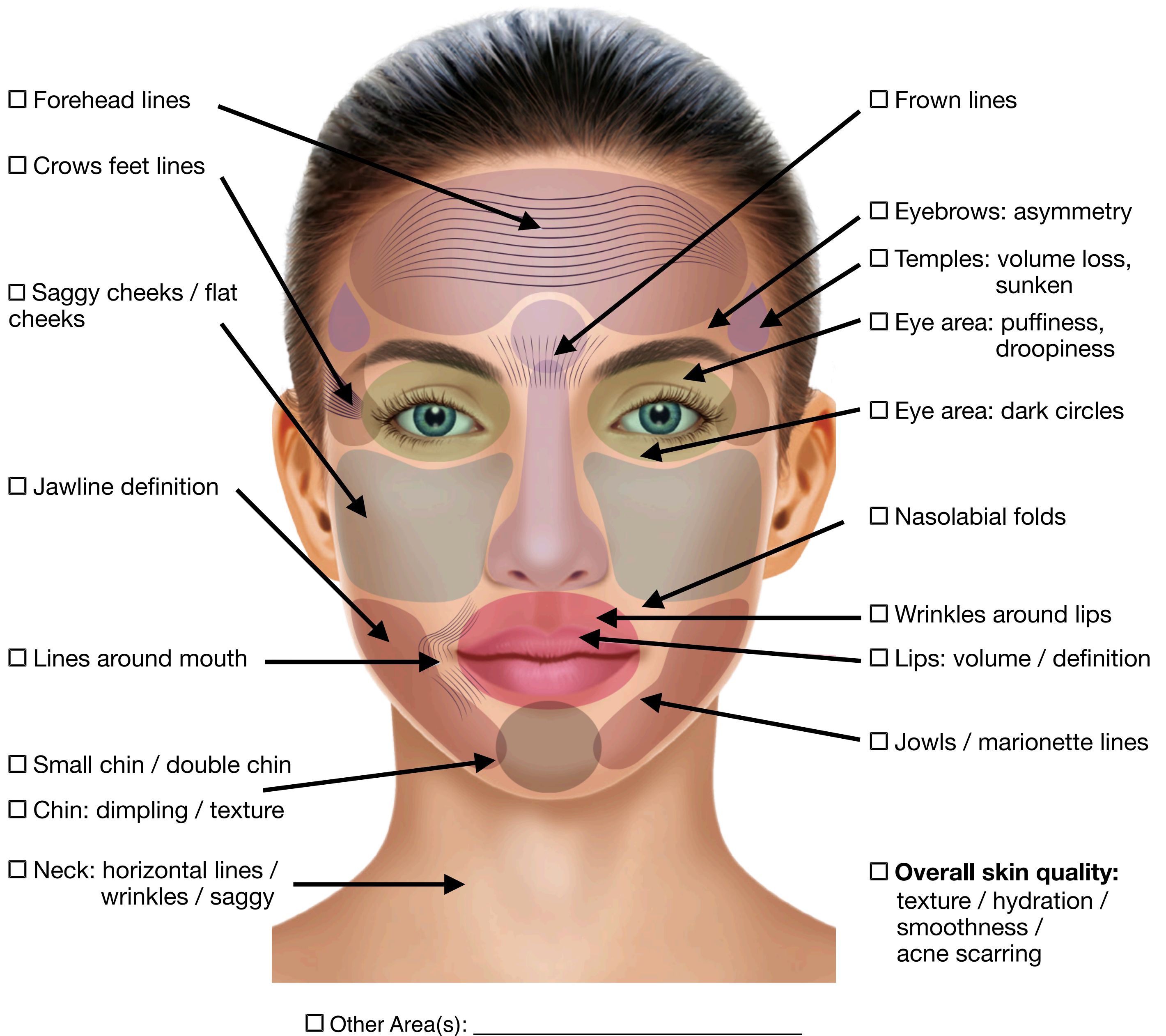
____

TREATMENT MOTIVATION (check **3** boxes - rank your top 3 motivations for treatment in order of importance - 1, 2, 3)

☐ I would like to look less tired	☐ I would like to look less sad	☐ I would like to look more attractive	☐ I would like to look more contoured
☐ I would like to look less saggy	☐ I would like to look less angry	☐ I would like to look younger	☐ I would like to look more feminine/ masculine

AREAS OF CONCERN

(please check areas, rank in order of importance to you)



Thank you for completing this intake form prior to your consultation with Beauty Within Medical Aesthetics.

We look forward to meeting you and designing a treatment plan unique to you and your aesthetic goals!

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